Dr. Kumar for Kids

Sarasa Kumar MD, Inc • 13768 Roswell Avenue, Suite 205, Chino, CA 91710 • Tel: (909) 590-7356 • Fax: (909) 548-6871

CONSENT FOR NON - GUARDIAN TO AUTHORIZE TREATMENT

Child's Full Name _____

Date of Birth ____/____/____

I, _____ (Parent/Legal Guardian of child mentioned above),

give _____ permission to authorize medical mentioned above), give _____ permission to authorize medical treatment for the above child.

Primary Doctor _____Hospital _____

Hospital Phone (_____) _____ - _____

Insurance_____ Member ID # _____

Signed _____ Date ____/____/ ____

Relationship to Above Child _____

Witnessed the Above Signature_____ Date ____ /____ / ____

Effective Date:____ / ____/ ____ End Date: ____/____/ ____